

**STATEMENT OF FINANCIAL CONDITION**

<b>Last</b>	<b>First</b>	<b>MI</b>	<b>Social Security #</b>	<b>D.O.B</b>
<b>Home Telephone #</b>		<b>Emergency Contact Telephone #</b>		<b>Alternate Contact Telephone #</b>
<b>Address: Street</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Employer: Company Name</b>			<b>Business Phone #</b>	
<b>Employment Address: Street</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Spouse Employer: Company Name</b>			<b>Business Phone #</b>	
<b>Spouse Employment Address: Street</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>

**Income Information: Last 12 Months Gross Income**

	Patient	Spouse	
<b>Family Size:</b>			<b>Was your Medical condition a result of an accident or injury?</b>
Patient's Gross Income:	\$	\$	<b>Yes or No</b> _____
Other Family Income:	\$	\$	
Interest and Dividends:	\$	\$	
Real Estate or Personal Property:	\$	\$	<b>Have you retained the services of an attorney? Yes or No</b> _____
Social Security:	\$	\$	
State Financial Assistance:	\$	\$	
Other Income: (please specify)	\$	\$	<b>Attorney Name:</b> _____
Alimony or Child support payments made: (subtract)	\$	\$	
Current Monthly income	\$	\$	<b>Attorney's Tel#:</b> _____
<b>Total Combined Income:</b>	\$	\$	

**Monthly Allowable Expense Information Payment**

<input type="checkbox"/> Rent <input type="checkbox"/> Own	Mthly	\$
Utilities	Mthly	\$
Food Allowance	Mthly	\$
Other Allowable Expenses	Mthly	\$
<b>Total Monthly Expenses</b>		\$

**Other Considerations**

<b>Child Care / Babysitter</b>	Yes	No
<b>Single Parent caring for elders</b>	Yes	No
<b>Cost to provide services exceeds third party reimbursement</b>	Yes	No
<b>Emergency Services?</b>	Yes	No
<b>If patient is deceased is there an estate?</b>	Yes	No

By signing this form I agree to allow Holy Cross Hospital and/or Holy Cross medical group to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount. I understand that I may be required to provide proof of the information listed on the application. I certify that the above information is true and accurate to the best of my knowledge. Further, I understand that I am to apply for any assistance via State county or federal funding, which may be available for payment of my hospital visit, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this charity application applies only to the dates of service and corresponding account numbers referenced on this application for Holy Cross Hospital and Holy Cross Medical Group and that I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists. Unless patient requires a course of treatment based on one diagnosis a new charity form must be submitted for every date of service. I understand that this charity application applies to only Holy Cross Hospital and Holy Cross Medical Group accounts and I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists.

**Date of Request:** \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_

Reviewed by \_\_\_\_\_  
Rev 3/27/2006

\_\_\_\_\_  
Date  
1



4725 North Federal Highway  
Ft. Lauderdale, FL 33308  
(954)-771-8000 – Main Hospital Campus  
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## **FINANCIAL EVALUATION**

### **Information Necessary to Establish Eligibility:**

1. Tax Return with W-2/1099 Form for the prior year to include ***ALL PAGES***.
2. Notarized Affidavit Affirming Income ***ENCLOSED***.
3. Recent bank statement for the last (3) months to include ***ALL PAGES***.
4. Recent pay stub or Other Proof of Income for the ***LAST 12 MONTHS***.
5. You must apply for Medicaid if denied, a copy of your determination letter needed for file.
6. Copy of ID required.

**Holy Cross Hospital and Holy Cross Medical Group reserves the right to ask for additional information as necessary to process the Funding Assistance Application.**

**This application needs to be returned in 15 days.**

Upon receipt of all of the required information identified above, your application will be reviewed, and you will be made aware of the determination.

**Failure to submit requested information will result in automatic denial of extended payments or financial assistance benefits.**



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**NOTARIZED SUPPORT LETTER**

Date \_\_\_\_\_

To Whom It May Concern:

I, \_\_\_\_\_, do hereby certify that I am the sole financial support Or  
 \_\_\_\_\_ I am providing his/her room and board for the past  
 \_\_\_\_\_ years/months.

\_\_\_\_\_  
 Patient Print

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Person of Support Print

\_\_\_\_\_  
 Person of Support Signature

\_\_\_\_\_  
 WITNESS NAME

\_\_\_\_\_  
 WITNESS NAME

Sworn and subscribed before me this \_\_\_\_\_ day of  
 \_\_\_\_\_ 2010, by \_\_\_\_\_ who is  
 personally known to me/or produced \_\_\_\_\_ as identification.

\_\_\_\_\_  
 Notary Public, State of Florida



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## FUNDING ASSISTANCE/INCOME INDIGENCY ATTESTATION STATEMENT

**Patient Name:** \_\_\_\_\_  
**HCH Account Number:** \_\_\_\_\_

I, \_\_\_\_\_ certify, under the penalty of law that my family income for the past twelve (12) months has been \$\_\_\_\_\_, and that there are \_\_\_\_\_ people in my household/immediate family. I certify that I reside in \_\_\_\_\_ County/Country.

This income information can be verified by calling the following employer(s):  
\_\_\_\_\_ (Company Name & Phone Number)  
\*If not currently employed please indicate such on the above line by writing “not employed”.

Additionally, I understand that in accordance with S.817.50, providing false information to defraud a hospital for the purposes of obtaining goods for services is a misdemeanor in the second degree.

\*By signing this form I agree to allow Holy Cross Hospital to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount.

_____	_____	_____	_____
Guarantor Name	Date	Guarantor Signature	Date
_____	_____	_____	_____
Witness	Date	Relationship to Patient	

State of Florida  
County of Broward  
The foregoing instrument was acknowledged before me this \_\_\_\_\_  
by \_\_\_\_\_, who is personally known to me or who has proved  
\_\_\_\_\_ as identification and who did/did not take an oath.

\_\_\_\_\_  
Notary Public                      Date



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**FEDERAL POVERTY:**

For all states (except Alaska and Hawaii) and for the District of Columbia

Size of family unit	100% of poverty	110% of poverty	125% of poverty	150% of poverty	175% of poverty	185% of poverty	200% of poverty
1	\$10,830	\$11,913	\$13,538	\$16,245	\$18,953	\$20,036	\$21,660
2	\$14,570	\$16,027	\$18,213	\$21,855	\$25,498	\$26,955	\$29,140
3	\$18,310	\$20,141	\$22,888	\$27,465	\$32,043	\$33,874	\$36,620
4	\$22,050	\$24,255	\$27,563	\$33,075	\$38,588	\$40,793	\$44,100
5	\$25,790	\$28,369	\$32,238	\$38,685	\$45,133	\$47,712	\$51,580
6	\$29,530	\$32,483	\$36,913	\$44,295	\$51,678	\$54,631	\$59,060
7	\$33,270	\$36,597	\$41,588	\$49,905	\$58,223	\$61,550	\$66,540
8	\$37,010	\$40,711	\$46,263	\$55,515	\$64,768	\$68,469	\$74,020

For family units with more than 8 members, add \$3,740 for each additional person at 100% of poverty; \$4,114 at 110 %; \$4,375 at 125%; \$5,610 at 150%; \$6,545 at 175%; \$6,919 at 185% and \$7,480 at 200% of poverty.

Note: For optional use in FFY 2009 and mandatory use in FFY 2010.